Interviews with Culture-Specific Experts

Cultural competence involves not only a general awareness of the importance of cultural issues, but knowledge of culture-specific issues as well. Here, nine highly esteemed scholars and practitioners in the field of cultural competence respond to the same set of five questions about particular cultural groups with whom they have a special expertise. The cultural groups discussed are defined by ethnicity, religion, sexual orientation, or gender. As you read through them, take note not only of the unique issues related to clinical work with members of a particular culture, but of the similar themes that emerge as these experts share their wisdom and suggestions.

Melba Vasquez, Ph.D.
Latino/Latina clients

Biographical Sketch

Dr. Melba Vasquez is a psychologist in independent practice in Austin, Texas. She served as president of the Texas Psychological Association, past president of APA Divisions 35 (Society of Psychology of Women) and 17 (Society of Counseling Psychology), and as the first Latina member-at-large, APA Board of Directors. She is a Fellow of the APA and holds the Diplomate of the American Board of Professional Psychology. She is a co-founder of APA Division 45, Society for the Psychological Study of Ethnic Minority Issues, and of the National Multicultural Conference and Summit. She publishes in the areas of ethics, ethnic minority psychology, psychology of women. She is co-author, with Ken Pope, of Ethics in Psychotherapy & Counseling: A Practical Guide (2007, 3rd edition) and of How to survive and thrive as a therapist: Information, ideas and resources for psychologists in practice (2005).

1. In general, why is it important for clinical psychologists to be culturally competent when working with members of Latino/Latina culture?

Our world is more diverse than ever before. The demographic changes in the world and in this country have significant implications for counseling and clinical psychologists. Although Latinos/Latinas typically present with similar problems, relative to other clients, variations in conceptualizations and interventions may be important in providing effective services.

The more we understand about those with whom we work, including understanding their worldview and perspective, the more likely we are to promote a psychotherapeutic alliance (the most important variable in effective therapy outcome studies). This implies learning as much as possible about the various values, norms and expectations of various ethnic and racial group members with whom one works. The challenge in learning about cultural groups is to avoid stereotyping; rather, the knowledge is to be used to assess the degree of application of various cultural values, behaviors and expectations.

For example, domestic violence among Latino families occurs as frequently as in Caucasian families, but as with other problems, they are culturally mediated. In one study (Welland &Ribner 2007) the authors developed an intervention with 150 Latino men who completed a year of court-ordered treatment in Southern California. After listening how Latino men think about manhood (machismo) interpersonal relationships (respeto, personalismo), and family life (familismo), they helped the men, in group context, identify the aspects of masculinity in Latino culture that makes partner violence unacceptable.

In addition, all individuals are affected by unconscious negative biases, including providers of psychological services. Cultural competence includes a wide variety of strategies to become more aware of those biases, and to develop personal attributes to challenge negative socialized biases.

2. What can clinical psychologists (or students in training) do to enhance their cultural competence with members of Latino/Latina culture?

1) Develop awareness of one's attitudes toward those different from oneself, especially those whose identities are negatively constructed in society. The social psychological literature tells us that our social structures have compounding effects on our cognitive structures, and ultimately our social attitudes and our beliefs about people. The way society constructs societal representations of groups affects the social order, and has tremendous impact on the identities of individuals in various groups, both ethnic minority and White majority.

Consequently, we need to work to not only tolerate differences, but also to value and appreciate them. One strategy from the social psychological literature is to approach experiences and different experiences with curiosity and openness (rather than with distance, skepticism and criticalness).

2) Learn as much as possible about the particular Latino/a culture of those with whom they work, including worldview and perspective. It is important to learn as much as possible about the various values, norms and expectations of groups, but without stereotyping and generalizing those for every individual. Rather, use the knowledge to assess the degree of application of those for each person.

3) Keep up with the explosion of evidence-based research about the populations with whom they work by taking continuing education classes, attending culturally relevant events, consulting, reading, etc.

3. What specific considerations should clinical psychologists keep in mind when conducting assessment (interviewing, intelligence testing, personality testing, etc.) and diagnosis with members of Latino/Latina culture?

Multiculturally sensitive practitioners are encouraged to be knowledgeable of the limitations of assessment practices, from intakes to the use of standardized assessment instruments (APA, 2002; Constantine, 1998). *The APA Ethics Code (2002) urges psychologists to "use assessment instruments whose validity and reliability have been established for use with members of the population test. When such validity or reliability has not been established, psychologists describe the strengths and limitations of test results and interpretation" (p. 1071).* In addition, psychologists are urged to attend to the issue of an individual's *language preference*. Other ongoing areas of research focus on identifying issues around translation of instruments, the appropriate or inappropriate use of instruments, identifying different scores that may be more accurate for various groups, and so on.

Latino/a cultural factors for assessment may include relevant generational history (e.g., number of generations in the country, manner of coming to the country); citizenship or residency status (e.g. number of years in the country, parental history of migration, refugee flight, or immigration); fluency in "standard" English or other language, extent of family support or disintegration of family; availability of community resources; level of education, change in social status as a result of coming to this country (for immigrant or refugee); work history, and level of stress related to acculturation and/or oppression (APA, 2003)

4. What specific considerations should clinical psychologists keep in mind when conducting psychotherapy with members of Latino/Latina culture?

Knowledge of Latino/a cultural values, norms, and expectations is one important area already described, as is awareness of one's attitudes, particularly in regard to biases. Knowing when and how a psychotherapy client's problems are related to cultural background and experiences and suggesting therapeutic interventions based on cultural insight is important consideration, as well.

One of the major issues that presents an overlay to the general problems presented is that most racial/ethnic minority clients will have a historical and/or personal experience of oppression and biases. Historical experiences for various populations differ. This may be manifested in the expression of different belief systems and value sets among clients and across age cohorts. For example, therapists are strongly encouraged to be aware of the ways that enslavement has shaped the worldviews of Latinos/as. At the same time, the within-group differences among Latinos/as also suggest the importance of not assuming that all persons of Latino/a background will share this perspective. Thus, knowledge about sociopolitical viewpoints and ethnic/racial identity literature would be important and extremely helpful when working with individuals of racial/ethnic minority descent (see McGoldrick, Giordano, & Garcia-Preto, 2005, for a comprehensive resource for understanding families and histories in relation to ethnic heritage).

Culturally centered practitioners assist clients in determining whether a problem stems from institutional or societal racism (or other prejudice) or individual bias in others so that the client does not inappropriately personalize problems (Helms & Cook, 1999).

Consistent with the discussion in Multicultural Guideline #2, psychologists are urged to help clients recognize the cognitive and affective motivational processes involved in determining whether they are targets of prejudice.

It is also helpful to recognize, according to one of the assumptions of the Multicultural Guidelines (APA, 2003), the ways in which the intersection of racial and ethnic group membership with other dimensions of identity is important. Gender, age, sexual orientation, disability, religious/spiritual orientation, educational attainment and experiences, and socioeconomic factors are examples of other dimensions of identity that enhance or detract from one's identity and influence the way we relate to our clients.

5. Any other thoughts about culturally competent practice with members of Latino/Latina culture?

We must make an effort to be cognizant of the potential to treat people unfairly. It is challenging, but we must prevent a situation in which a client/patient may perceive offense without the psychotherapist's awareness that it was perceived as offensive.

I indicated previously that many stereotypes and generalizations, and the ensuing behaviors, are often, if not usually, *subconscious.* Typically, others have to bring those to our attention. *No one* is immune to these processes, including ethnic minority psychologists, including about own ethnic group members. "Internalized racism" is a dynamic that we all work against, but that can be subtle, unconscious, and powerfully destructive.

Resources:

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57,* 1060–1073.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58,* 377–402.

Constantine, M. G. (1998). Developing competence in multicultural assessment: Implications for counseling psychology training and practice. *Counseling Psychologist, 26,* 922–929.

Helms, J. E., & Cook, D. E. (1999). *Using race and culture in counseling and psychotherapy: Theory and process.* Boston: Allyn & Bacon.

McGoldrick, M., Giordano, J., & Garcia-Preto, N. (Eds.). (2005). *Ethnicity & family therapy* (3rd ed.). New York: Guilford.

Welland, C. & Ribner, N. (2007). Healing From Violence: Latino Men's Journey to a New Masculinity. New York: Springer.

Frederick Leong, Ph.D.
Asian-American clients

Biographical Sketch

Dr. Frederick Leong is Professor of Psychology at Michigan State University and serves as the Director of the Center for Multicultural Psychology Research. He has authored or co-authored over 120 articles in various psychology journals, 80 book chapters, and edited or co-edited 10 books. Dr. Leong is a Fellow of the APA and APS. He is the Founding Editor of the *Asian American Journal of Psychology*. His major clinical research interest centers around culture and mental health and cross-cultural psychotherapy and his I-O research is focused on cultural and personality factors related to career choice, work adjustment, and occupational stress.

1. In general, why is it important for clinical psychologists to be culturally competent when working with members of Asian and Asian American cultures?

I served as the Editor-in-Chief of the *Encyclopedia of Counseling* for Sage Publications (Leong, 2008). In that Encyclopedia, Arpana (Annie) Gupta and I wrote the entry on Counseling Asian Americans (Leong & Gupta, 2008). We defined Asian Americans as Americans of Asian descent. As one of the fastest growing ethnic minority groups, Asian Americans constitute approximately 14.0 million U.S. residents. Intra-group heterogeneity is particularly important to recognize when it comes to a group such as Asian Americans given that this population comprises of approximately 43 different ethnic groups with over 100 languages and dialects represented. According to the recent Census, 2.3 million individuals speak Chinese at home, the second most widely used non-English language in the U.S. The immigration history and status of this group is also diverse. The Census estimate is that 8.7 million U.S. residents are born in Asia, one-forth of the nation's total foreign-born population and 52% of foreign-born Asians are naturalized U.S. citizens. The median household income for Asians in 2004 was $57,518, the highest among all race groups. On the other hand, diversity of income within the Asian population was also evident with median household income for Asian Indians at $68,771 while the comparable income level for Vietnamese is $45,980. Asians have the highest proportion of college graduates of any race or ethnic group in the U.S. with 49% of individuals ages 25 and older holding a bachelor's degree or higher level of education and 87% of individuals with high school diplomas and 20% with advanced degree (e.g., master's, Ph.D., M.D. or J.D.). The projected number of U.S. residents who will identify themselves as Asian is 33.4 million in 2050, 8% of the total projected U.S. population. Specific to clinical psychology, the Asian American population also experience a couple of unique mental health service problems which I will describe below.

2. What can clinical psychologists (or students in training) do to *enhance* their cultural competence with members of Asian and Asian American cultures?

Besides realizing that there is a great deal of variability within the Asian American subgroups, I would point to the need to study and understand the cultural values and worldviews of Asian Americans. Annie Gupta and I (Leong & Gupta, 2008) summarized the Asian American worldview as emphasizing "humility, modesty, treating oneself strictly while treating others more leniently, obligation to family, conformity, obedience, and subordination to authority. This cultural context also values familial relations, interpersonal harmony versus honesty emphasis, role hierarchy versus egalitarianism, and self-restraint versus self-disclosure". We also highlighted the importance of understanding that acculturation serves as a major moderator of the diversity within Asian Americans. Acculturation involves a cultural or ethnic minority individual's behavioral, cultural, and social adaptations that take place as a result of contact between the individual's culture of origin and the host culture. Clinicians have pointed out that many Asian Americans experience cultural conflicts during this process that some times result in mental health issues and interpersonal problems. These Asian Americans are often caught between the Western worldviews and the traditional cultural values as they attempt to negotiate between the two cultures. As they became exposed to Western influences, intergenerational conflicts can result within family units as well. Helping Asian Americans resolve the cultural conflicts generated by the acculturation process is major issue that clinicians will need to attend to in their work with this population. Finally, Annie and I also pointed out that family plays a central role in the well being and adjustment of Asian Americans. For many Asian Americans, constancy and equilibrium, duty, obligation and appearance of harmonious relations are important in their family relations. In addition, Asian families tend to emphasize connectedness of the family, while European Americans tend to prioritize separateness and clear boundaries in relationships due to the two groups value differences. It has become well known that Asian Americans tend to be more collectivistic in cultural orientation while European Americans tend to be individualistic. Since women tend to acculturate faster than men and children and youth faster than older adults, the families of Asian Americans not only have the potential of facilitating mental health, but could also serve as potential mental health stressors due to these intergenerational and gender differences in acculturation levels.

3. What specific considerations should clinical psychologists keep in mind when conducting *assessment* (interviewing, intelligence testing, personality testing, etc.) *and diagnosis* with members of Asian and Asian American cultures?

I am actually working on a paper regarding the threats to cultural validity in clinical diagnosis with Asian Americans for a book on Evidence Based Practice (EBP) in psychological interventions. According to Anastasi (1976), the validity of a procedure concerns what the procedure measures and how well it does so. Inasmuch as reliability is concerned with the consistency of a particular procedure, validity is concerned with its accuracy. The issue of cultural validity is therefore concerned with the accuracy of clinical diagnosis for culturally-different populations (e.g., racial or ethnic minorities). Clinically, the lack of cultural validity may result in incorrect diagnosis and ineffective treatment of culturally different populations. Socially, such individuals may be unnecessarily stigmatized and institutionalized due to the diagnostic errors. There are several major factors which may contribute to the lack of cultural validity in clinical diagnosis. Borrowing from Campbell and Stanley's (1966) concept of threats to validity, I proposed that the lack of cultural validity in clinical diagnosis can also be conceptualized in terms of multiple threats to validity. In my review, I point out that these threats to cultural validity in diagnosis are due largely to a failure to recognize or a tendency to minimize

cultural factors in clinical diagnosis. The literature suggests that there are several factors which may serve as the sources of threats to cultural validity. These factors include: (a) pathoplasticity of psychological disorders (e.g., culture influences the variability in symptoms, course, outcome, and distribution of mental disorders among racial and ethnic groups), (b) cultural factors influencing symptom expression (e.g., Asian Americans, compared to European Americans, have been found to manifest different symptoms or similar symptoms at different times even when diagnosed with the same disorder), (c) therapist bias in clinical judgment (clinicians from different racial and ethnic group arrive at different diagnosis when viewing the same patient), (d) language capability of the client (e.g., African American patients with dialects receive worse diagnosis than those without dialect), and, (e) inappropriate use of diagnostic and personality tests (e.g., using tests that contain culturally inappropriate items or scoring test results with inappropriate cultural norms).

4. What specific considerations should clinical psychologists keep in mind when conducting *psychotherapy* with members of Asian and Asian American cultures?

As mentioned above, Asian Americans, similar to other racial and ethnic minority groups have experienced specific problems with regards to the mental health system in the United States. I am referring to the twin problems of underutilization of mental health services and premature termination from treatment among Asian Americans.
In general, it is the cultural differences among Asian Americans, vis-a'-vis European Americans, in attitudes, values, norms and beliefs that serve as barriers to their seeking professional psychological help. I will provide a list of resources for the reader to become familiar with these attitudes, values, norms and beliefs in my final response below. Awareness of these attitudes, values, and beliefs will help shed light to how to provide more culturally relevant and effective therapy to this population. At the same time, we need to continue research to ascertain the actual mechanisms underlying how and why these variables actually affect Asian Americans in terms of psychotherapy. For example, research has found that Asian Americans tend to exhibit greater respect for counselors, preference for a counselor who is an authority but is not authoritarian, tendency to exhibit lower levels of verbal and emotional expressiveness, preference for directive counseling styles, crisis-oriented, brief, and solution-oriented approaches rather than insight and growth-oriented approaches. Asian Americans are likely to find difficulty with the western model of counseling and psychotherapy which is filled with ambiguity by design and typically conducted as an unstructured process. Could it be that Asian Americans have these attitudes and beliefs that affect them in psychotherapy because they have a lower tolerance of ambiguity which in turn leads to a mismatch for them with insight-oriented psychotherapy. Is it possible that this mismatch in cultural cognition and expectations that may account for their early termination and the underutilization rates mentioned above. Similarly, Asian cultural values of reserve, restraint of strong feelings, and subtleness in approaching problems may come into conflict with western model of counseling and psychotherapy which expects clients to exhibit openness, psychological mindedness, and assertiveness. Assuming that these differences are recognized, how should clinicians manage these cultural differences in attitudes, values and beliefs?

5. Any other thoughts about culturally competent practice with members of Asian and Asian American cultures?

The cross-cultural competence movement started by Derald Sue and his colleagues in the Counseling Division (Division 17) of the APA noted that there are three components to culturally competence counselor and psychotherapist: Awareness (Attitudes and Beliefs), Knowledge, and Skills. In the last 25 years, we have made significant strides in the first component (Awareness)

and it is time for us to focus more on the second and third component. Specific to the Knowledge component, I recommend that clinicians and graduate students in preparation to become clinicians, work to acquire culture-specific information about the culturally different clients whom they serve. For Asian Americans, there are a series of books and chapters that would be valuable to become familiar with in this respect. Given below is a list of these resources. In addition, the Asian American Psychological Association has also recently launched the *Asian American Journal of Psychology* founded by me. It would be good to check that journal for the most up to date information in Asian Americans: http://www.apa.org/journals/aap/

Resources:

Hall, G. C. N., Okazaki, S. (2002). *Asian American Psychology: The Science of Lives in Context*. Washington, DC: American Psychological Association.

Kurasaki, K. S., Okazaki, S., Sue, S. (2002). *Asian American Mental Health: Assessment Theories and Methods*. New York, New York: Kluwer Academic/Plenum Publishers.

Lee, C. L., Zane, N. W. S. (1998). *Handbook of Asian American Psychology*. Thousand Oaks, CA: Sage Publications, Inc.

Leong, F. T. L., Inman, A., Ebreo, A., Yang, L. H., Kinoshita, L., Fu, M. (2007). *Handbook of Asian American Psychology*. 2nd ed. Thousand Oaks, CA: Sage Publications, Inc.

Sue, S., Morishima, J. (1982). *The Mental Health of Asian Americans: Contemporary Issues in Identifying and Treating Mental Problems*. 1st ed. San Francisco, CA: Jossey-Bass Inc.

Tewari, N., Alvarez, A. (2009). *Asian American Psychology: Current Perspectives*. New York, New York: Taylor & Francis Group, LLC.

Uba, L. (1994). *Asian Americans: Personality Patterns, Identity, and Mental Health*. New York, New York: The Guilford Press.

Joseph E. Trimble, Ph.D.
American Indian/Alaska native clients

Biographical Sketch

Joseph E. Trimble (PhD, University of Oklahoma, Institute of Group Relations, 1969) is a Distinguished University Professor and member of the Department of Psychology and a Research Associate in the Center for Cross-Cultural Research at Western Washington University in Bellingham, Washington. Also, he is a Senior Scholar at the Tri-Ethnic Center for Prevention Research and an Adjunct Professor of Psychology at Colorado State University and a Research Associate for the National Center for American Indian and Alaska Native Mental Health Research at the University of Colorado Health Sciences Center. From 2000-2001, he was a Fellow at the Radcliffe Institute for Advanced Studies at Harvard University. And in March 2007, he was the O'Brian Visiting Professor at Scripps College.

Dr. Trimble earned a baccalaureate degree from Waynesburg College (now University) in 1961 and pursued graduate studies in psychology at the University of New Hampshire and the University of Oklahoma. In addition, he pursued postdoctoral studies at the University of Colorado, Ohio University, and the University of Hawai'i-Manoa, /East-West Center in Honolulu, Hawaii.

Throughout his career, he has focused his efforts on promoting psychological and sociocultural research with indigenous populations, especially American Indians and Alaska Natives. For the past 25 years, he has been working on drug abuse prevention research models for American Indian and Alaska Native youth. He has collaborated on a series of studies concerning the etiology of drug abuse among American Indian youth, and has been involved in promoting drug use research among America's ethnic minority populations. Since 1972, he has served as a member of numerous scientific review committees and research panels for the following federal agencies: NIAAA; NIDA; NIA; NIMH; National Heart, Lung and Blood Institute; NICHD; NCI; National Center for Research Resources, NIH; Risk, Prevention, and Health Behavior, NIH; Center for Substance Abuse Prevention; National Academy of Sciences; NSF; NIDA's Subcommittee on Epidemiology and Prevention Research, Risk, Prevention: and the Center for Scientific Review's Health Behavior Initial Review Group; and NIDA's Health Services Research Subcommittee.

Dr. Trimble has held offices in the International Association for Cross-Cultural Psychology and the American Psychological Association; he holds Fellow status in three divisions in the APA

(Divisions 9, 27, and 45). He is past-President of the Society for the Psychological Study of Ethnic Minority Issues (Division 45 of the American Psychological Association) and a Council member for the Society for the Psychological Study of Social Issues (Division 9 of the American Psychological Association). In 1994, he received a Lifetime Distinguished Career Award from the American Psychological Association's Division 45 for his research and dedication to cross-cultural and ethnic psychology. In 1991, he received a Certificate of Commendation for Outstanding Contributions to the Development and Implementation of the National Institute on Drug Abuse's Special Populations Research Programs. And, in 2001, he was awarded the Eleventh Annual Janet E. Helms Award for Mentoring and Scholarship in Professional Psychology at the Teachers College, Columbia University, 18th Annual Roundtable on Cross-Cultural Psychology and Education. He has presented over 150 papers, invited addresses, and invited lectures at professional meetings, and has generated over 140 publications and technical reports on topics in psychology and higher education research including 17 authored or edited books. His co-edited book with Guillermo Bernal, Ann Kathleen Burlew, and Fred Leong, *the Handbook of Racial and Ethnic Minority Psychology*, was selected as CHOICE Magazine's Outstanding Academic Titles for 2004. His most recent books include (with Celia B. Fisher) *The Handbook of Ethical Research with Ethnocultural Populations and Communities* (Sage Publications) and (with Paul Pedersen, Juris Draguns, Walter J. Lonner) *Counseling Across Cultures, 6th Edition* (Sage Publications.

He is a dedicated teacher, researcher and scholar. He is the recipient of three awards from Western Washington University -- the Outstanding Teacher-Scholar Award in 1985, the Excellence in Teaching Award in 1987, and the Paul J. Olscamp Outstanding Faculty Research Award in 1999. In addition, the Washington State Psychological Association awarded him the Distinguished Psychologist Award for 2002. In 2004, he was the recipient of the Peace and Social Justice Award from the American Psychological Association's Division on Peace Psychology. In 2006, he received the Allen L. Edwards Lecturer Fellowship from the Department of Psychology at the University of Washington. In 2007, he was the recipient of the Distinguished Elder Award from the National Multicultural Conference and Summit. And in 2009 he received the Henry Tomes Award for Distinguished Contributions to the Advancement of Ethnic Minority Psychology from the American Psychological Association's Council of National Psychological Associations for the Advancement of Ethnic Minority Interests and the Society for the Psychological Study of Ethnic Minority Issues and the International Lifetime Achievement Award for Multicultural and Diversity Counseling by the University of Toronto's Ontario Institute for Studies in Education.

1. In general, why is it important for clinical psychologists to be culturally competent when working with members of American Indian/Alaska Native culture?

It is essential that counselors who work with Native American Indians understand the extraordinarily diverse demographic and individual identity characteristics of the groups that make up North America's indigenous populations. These populations are no doubt more diverse then those that make up the rich tapestry of national and ethnic groups in European countries. Native American Indians reside in all of Canada's provinces and in all of the U.S. states. Slightly less then 50% resides in urban areas, with the remainder living in rural villages and small rural communities and on reservations. An unknown number follow traditional lifestyles, and countless others embrace the values and lifestyles of the common North American culture. The amazing variation in lifestyle orientations and physical appearance among the Native populations presents a daunting challenge for anyone who tends to view American Indians as a homogeneous group.

Indeed, the tendency of non-Natives to view American Indians in a collective manner has been a source of considerable concern among scholars. It may well be the major reason so many non-Natives experience difficulty in understanding the complexity of the varied lifeways and thoughtways of Native American Indians.

Additionally, it is important to emphasize that people of American Indian and Alaska Native heritage have multiple identities. No one is solely Indian or Native, just as no one is solely a man or a woman. All persons, including Native American Indians, are members of particular age groups and have particular sexual orientations. They may have disabilities. In addition, they may follow vocations that provide them with unique identities. The enactment and nature of an Indian and Native individual's multiple identities can be influenced by that individual's tribal lifeways and thoughtways, which may be at variance with conventional expectations and proscriptions. A person's multiple identities, as well as the sociocultural contexts in which these identities are enacted, must be considered in any counseling setting.

2. What can clinical psychologists (or students in training) do to enhance their cultural competence with members of American Indian/Alaska Native culture?

At the outset, counselors must examine their motives for wanting to work in Indian and Native mental health settings and specifically with Indians and Natives from varied tribal backgrounds with varying degrees of Native identity. Writing in their well used counseling psychology textbook, *Using race and culture in counseling and psychotherapy: Theory and practice*, psychologists Janet Helms and Donelda Cook (1999) put the essence of multicultural counseling succinctly: "How can counselors resolve the different manners in which counselors and clients conceptualize mental health problems if the counselors and clients come from different culture-related life experiences?" They add, "To the extent that the therapists' and clients' socialization histories in either the racial or cultural domains of life have been incongruent, then one would expect differences in the ways in which therapists and clients conceptualize the problem for which help is sought, as well as what they consider to be appropriate 'treatment' for the problem" (p. 7). Ignoring or camouflaging these differences eventually leads to inadequate counseling and often to early client termination. Therefore, according to Helms and Cook, "gathering data regarding the client's racial history and examination of one's own racial attitudes towards members of the client's racial group should be a major part of the therapist's ongoing assessment procedures" (p. 8).

Certain critics of the cross-cultural counseling process believe that counselors must abandon conventional styles and wisdom to be effective in working with clients who come from cultures different from the counselors' own. I believe that such an approach is not only ill conceived, but foolish. Conventional counselors may possess generic personal characteristics that promote positive relationships with any clients, regardless of their racial or ethnic backgrounds. In fact, many conventional providers of mental health services share healing characteristics similar to those of shamans, spirit healers, and medicine people. Numerous researchers and scholars point out that "witch doctors" and psychiatrists have a great deal in common, despite differences in their approaches and cultural orientations. The similarities have to do with a healer's personal characteristics. Providers of traditional helping services in Indian communities most likely exemplify empathy, genuineness, availability, respect, warmth, congruence, and concreteness, characteristics that are likely to be effective in any therapeutic treatment setting, regardless of the provider's theoretical orientation or counseling style. Effective counseling with Indians begins when a counselor carefully internalizes and uses these basic characteristics in counseling settings.

Continuing with this theme, Catherine Reimer, a counseling psychologist and an Inupiat Eskimo, collected information from Inupiat Eskimo respondents in an Alaska village concerning the characteristics they found desirable in a traditional healer or shaman (1999). Her respondents indicated that a healer is (a) virtuous, kind, respectful, trustworthy, friendly, gentle, loving, clean, giving, helpful, not a gossip, and not one who wallows in self-pity; (b) strong physically, mentally, spiritually, personally, socially, and emotionally; (c) one who works well with others by becoming familiar with people in the community; (d) one who has good communication skills, achieved by taking time to talk, visit, and listen; (e) respected because of his or her knowledge, disciplined in thought and action, wise and understanding, and willing to share knowledge by teaching and serving as an inspiration; (f) substance-free; (g) one who knows and follows the culture; and (h) one who has faith and a strong relationship with the Creator. Thus counselors may have to put aside conventional counseling styles and pay attention to what Indian and Native clients value in respected healers. Moreover, having the ability to suspend disbelief is helpful for counselors working with Native clients—that is, counselors need to be willing to listen to and hear whatever clients may say without judging the credibility of the belief systems associated with healing ceremonies, Indian medicine, and spiritual quests.
Indian and Native clients may have other expectations of counselors that go beyond the establishment of the client-counselor relationship. As indicated above, Natives often see traditional healers as wise and knowing, thus it is possible that they will view counselors in a similar way.

Many counselors have been unsuccessful with Indian and Native clients, and not because of lack of effort and concern. Counselors may be unsuccessful in working with Indian and Native clients for a number of different reasons. Among the possibilities are the following: the counselor may lack basic knowledge about the client's ethnic and historical backgrounds; the client may be driven away by the professional's counseling style; the client may sense that his or her worldview is not valued; the client may feel uncomfortable talking openly with a stranger; or the ethnic background of the counselor may create client apprehension

3. What specific considerations should clinical psychologists keep in mind when conducting assessment (interviewing, intelligence testing, personality testing, etc.) and diagnosis with members of American Indian/Alaska Native culture?

Formal assessment of mental disorders through psychological testing presents a particularly knotty problem for counselors working with Indian and Native clients; indeed, testing is a general problem in cross-cultural work. The problem is both one of definition, regarding what constitutes psychopathology, and one of measurement. An example will help to illustrate the definitional issue. Not too long ago, a well-known American Indian psychologist was interviewing for a position at an Indian mental health facility; he was warned by a non-Indian social worker, "You had better bone up on personality disorders, because that is about all we deal with here." The basis of this person's contention was the routine administration of the Minnesota Multiphasic Personality Inventory to presenting clients in the setting. Quite clearly, the class of disorders measured by the MMPI is strongly shaped by cultural values, norms, and behaviors, and when applied cross-culturally, this instrument will reveal a high number of deviant.

Although mental disorders occur in all cultures, it is often difficult to determine what level of symptoms constitutes a problem that needs addressing; in essence, this is a measurement problem. For example, it has been found that the National Institute of Mental Health's Center for Epidemiological Studies Depression Scale can be used effectively to assess depression in Indian adolescents (Manson, Shore, and Bloom (1985). However, it is necessary to adjust the cutoff

scores for accurate diagnosis; applying the cutoffs that are considered appropriate for non-Indians will result in erroneous diagnosis and lead to insensitive and inappropriate treatment.

Several cross-cultural psychologists contend that, “comparing elements from differing societies leads to inadmissible distortions of reality” (Kobben, 1970, p. 584). Part of the problem stems from the possibility that the tests and measures are not culturally resonant with the population or ethnic group of interest. In effect, test developers appear to give little serious attention to issues of cultural measurement equivalence. Any psychological test’s content, format, and metric style must be congruent with and comparable within and across the cultural groups selected for study.

Achieving cultural measurement equivalence requires that a common measurement and assessment processes exist with an ethnocultural group. The principle holds that a universal process must be developed to demonstrate and assess ethnocultural group comparability. Consequently, to achieve functionality two or more behaviors must "pre-exist as naturally occurring phenomena" that are related or identical to a similar problem or circumstance; the behaviors serve a similar function for all groups involved in the comparison test findings. Conceptual and stimulus equivalence exists when the meaning of stimuli, concepts, methods, etc., are similar or identical for the culturally different respondents. Linguistic equivalence is similar although the emphasis is placed on the linguistic accuracy of item translations. Unfortunately, few researchers have actively sought to develop psychological measure that fit the basic criteria for cultural measurement equivalence with Indian and Native populations. Conventional standardized measures and tests typically used to assess mental health and psychological characteristics therefore must not be used at all or used with extreme caution unless the test developer has validated the measure and corresponding scales’ measurement equivalence with North America’s indigenous people.

The best general advice for counselors working with Indian clients is that they should treat all diagnostic data with caution. Objective assessment can be of value, but counselors must recognize that these data do suffer from cultural bias. We cannot offer a review of symptomatology and psychological assessment and testing here, but we recommend that counselors consult the literature before basing their counseling plans on psychological testing.

4. What specific considerations should clinical psychologists keep in mind when conducting psychotherapy with members of American Indian/Alaska Native culture?

Traditional counseling sessions conducted in health clinics tend to create high levels of apprehension and anxiety for traditional Indian and Natives. Clients might be wary of the possibility that someone at the clinic might recognize them and therefore may be reluctant to seek counseling under these circumstances. Consequently, the counselor should consider alternative sites for sessions that are familiar and comfortable for the client. Some possibilities include conducting some sessions in the client’s residence, at a comfortable and peaceful spot in their neighborhood or community, or in settings where the client feels relaxed and connected with the environment around them. A few counselors who work effectively with Indian and Native clients use a “walk and talk approach” where sessions occur on hikes in a forested area, along the wash of a river, or along a beach; sessions often continue when the couple rest and sit on beached logs, fallen trees, on large boulders strewn around the grounds, or a comfortable or spiritual place where the client feels the need to pause and reflect on the discussion. In essence, the counselor should be flexible in choosing the site that best accommodates the client’s need to be in a setting that allays fears and apprehensions about presenting problem and the counseling process.

Other ways in which counselors can work to be effective with Indian and other Native clients have been identified, including building trust and nurturing trustworthiness; in general, both are highly correlated with client self-disclosure. Self-disclosure typically is not consistent with traditional Indian and Native communication styles; nonetheless, trust building is essential, especially if a non-Indian counselor wants to establish mutual respect and rapport with an Indian client on a one-to-one basis. A few research studies found that Indian students clearly rated simulated interviews more positively when the counselors in the interviews, regardless of their own ethnicity, enacted trustworthy roles. Trustworthiness appeared to be enhanced for these researchers' respondents when the counselors used culturally appropriate communication styles and trust behaviors. But establishing trust may take several sessions to accomplish hence the counselor must be willing to be patient; trust will occur on the client's terms and from their cultural worldview.

Counselors interested and committed to working with indigenous peoples must recognize and honor the significance of spirituality. In his recent book, "Spirit Matters," Rabbi Michael Lerner (2000) says, that "Understanding the spiritual realm of human needs, and how the world gets distorted when our spiritual needs are thwarted, can provide us with a much deeper understanding of what's going on in this world and in our personal lives as well" (p. 1). For many indigenous people spirituality is about feeling and being connected – connected to friends, family, community, and the world around them. For client and counselor a belief and commitment to spirituality promotes and strengthens certain values that are related, in many ways, to values and beliefs about multiculturalism – embracing these values strengthen connectedness.

Spirituality is an intense experience of harmony but many Indian and Native clients experience identity through a sense of isolation and loneliness. Through a variety of circumstances clients believe they are disconnected from others and the world that brings comfort to them. The feeling of disconnectedness contributes to the feeling and belief that one is losing their identity; they may even believe that they have lost their identity entirely.

Merely acknowledging the meaning and importance of spirituality is not sufficient to establish deep-level, relational trust and rapport with the client. If necessary, the counselor should be willing to assist the client in exploring the meaning of spirituality and it's purpose in their current life situation; in fact, it may be that the client is struggling with spiritual beliefs even to the extent that they believe they may have violated certain facets of spiritual practices and beliefs.

5. Any other thoughts about culturally competent practice with members of American Indian/Alaska Native culture?

A constant theme occurs repeatedly in the Indian and Native counseling literature --counselors of Indian and Native clients must be adaptive and flexible in their personal orientations and in their use of conventional counseling techniques. According to the American Indian counseling psychologist, Roger Herring (1999), to achieve flexibility counselors should adopt a "synergetic orientation" to assist them in establishing a "culturally affirmative environment" (pp. 55, 58). Consistent with the recommendations of other scholars and counselors in the field, Herring maintains that counselors should: " 1) address openly the issue of dissimilar ethnic relationships rather than pretending that no differences exist; 2) schedule appointments to allow for flexibility in ending the session; 3) be open to allowing the extended family to participate in the session; 4) allow time for trust to develop before focusing on problems; 5) respect the uses of silence; 6) demonstrate honor and respect for the [client's] culture(s); and 7) maintain the highest level of

confidentiality" (pp. 55-56). Herring's suggestions reflect the sentiments and recommendations of many observers concerning the conduct of research in Indian and Native communities

Additionally, numerous clinical and counseling practitioners maintain that clients must be held accountable and therefore responsible for following through on negotiated agreements; in some instances, Indian and Native clients have been known to hold counselors responsible for the absence of change in the lives and thus terminate the relationship.

Thus, to assist clients in taking responsibility for most of their counseling and clinical progress, Indian and Native grounded feedback procedures can take many useful forms. However, the most useful approach is for the client and counselor to summarize the events, dialogue, and agreements at the end and the beginning of subsequent sessions. Some multicultural counselors ask clients to summarize the main points on small 3x5 cards or notepaper. Counselors review the summaries for clarification and accuracy and then give the written material to the client with the instructions that they review it before their next session. In subsequent summaries clients can jot down noticeable and positive emotional, cognitive, and behavioral changes that have occurred. Use of this technique serves to sustain the narrative, the process of self-discovery, confidence, self-mastery, and hope.

Use of counseling feedback strategies and techniques that resonate with Indian traditions and customs can be effective. Many Native and Indian counselors and clinicians recommend that counselors use humor, especially in the forms of storytelling.
Humor and art are very much a part of many traditional healing practices, thus these recommendations make good sense as they tie counseling procedures to the clients' traditions and customs.

Occasionally, with the assistance of local "community care takers" and family members, counselors may want to weave traditional healing approaches in with conventional techniques to effect a positive outcome and promote accountability. Winona Simms, an American Indian counseling psychologist (1999), describes use of a blended counseling approach that combined an integrated relational behavioral-cognitive strategy with traditional healing approaches, including talking circles, sweats, and participation in cultural forums; each of these approaches involves the constant use of feedback. The client that Simms describes was experiencing cultural identity, self-confidence, and academic problems that could not be resolved through the use of a straightforward conventional counseling technique.

When experiencing problematic life events some traditional Indian and Native clients believe that the problems will eventually fade away if one is willing to be patient and endure occasional emotional shock and psychological distress. Others believe that if they work harder and longer at something or engage in busywork the problems will decrease gradually in intensity and eventually disappear. In effect, a fatalistic orientation to one's problems is the dominant coping strategy and thus negatively influences the possibility of one taking actual control and power in bringing constructive change.

To shift the locus of evaluation away from a fatalistic orientation an approach worth considering is use of a "mirroring technique." Inviting family members or trusted community members into selected counseling sessions can facilitate the effectiveness of the technique. With their assistance of co-counselors the client's discussions and enactments of the stressors and their compounding problems can be "mirrored" or "reflected" back to the client. In effect, after the client describes their feelings and thoughts others "mimic" or "mirror" the descriptions allowing the client to

experience what they present to others; the technique can assist client and counselor to identify client insights and possible sources of resistance. Potential sources of change can flow from the experience and guide the comprehension and fulfillment of client goals.

Resources:

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Lerner, M. (2000*). Spirit matters*. Charlottesville, VA: Hampton Roads.

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Robert L. Williams, Ph.D.
African-American clients

Robert L. Williams was born in Arkansas. He graduated from Dunbar High School (Little Rock, Arkansas) in 1947. He attended Dunbar Junior College for one year (1947-48). He earned a BA degree in 1953 (cum laude and Distinction in Field) from Philander Smith College (Little Rock, Arkansas); M.Ed. in 1955 from Wayne State University (Detroit, Michigan) with a major in Educational Psychology; Ph.D. in 1961 from Washington University (St. Louis, Missouri) with a major in Clinical Psychology.

Dr. Williams' expertise is in the area of Black Psychology, Cultural Diversity, Race Relations, Black language and program evaluation.

Dr. Williams has served as Staff Psychologist, Arkansas State Hospital; Chief Psychologist, VA Hospital in St. Louis, Missouri; Director of a Hospital Improvement Project in Spokane, Washington and Consultant for the National Institute of Mental Health, San Francisco, California. Dr. Williams retired in 1992 from Washington University. He is Professor Emeritus of Psychology and African-American Studies at Washington University, St. Louis, Missouri. Dr. Williams returned to the academy in the fall of 2001 as The Distinguished Visiting Professor of Black Studies at the University of Missouri-Columbia.

1. In general, why is it important for clinical psychologists to be culturally competent when working with African Americans?

Very simply, the more the psychologist knows and understands the cultural values of African Americans, the more effective they'll be in working with them. Research by Horace Mitchell, who is now president of Cal State University Bakersfield, has suggested that counselors with high familiarity with the black experience demonstrated more openness and empathy toward their black clients (e.g., Mitchell, 1971, 1974). The clients of these types of therapists were more trusting than those of therapists with lower familiarity with the black experience. My assessment tool, the Black Intelligence Test of Cultural Homogeneity (BITCH; Williams, 1972) was used in some of his research. A psychologist's familiarity with the black experience comes across to clients. It doesn't require a deliberate effort or extensive self-disclosure by the therapist.

There's a saying in the black community: How do you know where I'm at if you haven't been where I've been? Culturally incompetent psychologists won't know where the problems really lie, because they lack knowledge and familiarity with where the black client has been.

Perhaps most importantly, psychologists working with clients of diverse backgrounds, including African American clients, need to know and accept that a *cultural difference is not a deficiency.* In other words, differences between the cultures exist, but they need not suggest that one is better or worse than the other. A cultural difference between a client and a psychologist doesn't mean that the client is deficient in some way.

2. What can clinical psychologists (or students in training) do to enhance their cultural competence with African Americans?

Training programs and continuing education programs should include courses in black studies, multicultural studies, etc., that emphasize acquisition of knowledge, concepts, and values. For example, it's important for psychologists to learn about linguistic patterns that may differ between cultures, and about different types of racism, including individual racism and institutional racism.

There's a lot to learn from textbooks, but additionally, direct contact with African Americans in the community is crucial. The clinical practicum is one way to get this experience. Many white psychology students have had minimal experience with African Americans, so the more hands-on experience they can get, the better they will be able to recognize and overcome stereotypes and gain sensitivity to the clients' experience.

3. What specific considerations should clinical psychologists keep in mind when conducting assessment (interviewing, intelligence testing, personality testing, etc.) and diagnosis with African Americans?

Primarily, psychologists should know the history of bias in psychological testing with African American clients. They should know about IQ test bias, which is connected to educational tracking, in which gifted programs have often been biased in favor of accepting high income or white students while lower income students have often been tracked into special education programs. In general, psychologists should be fully aware of the cultural bias involved in testing, especially as it affects African American clients.

4. What specific considerations should clinical psychologists keep in mind when conducting psychotherapy with African Americans?

The first step in gaining cultural competence is self-knowledge. Psychologists need to become aware of their own racial scripts and beliefs, and how these might affect the way they conduct therapy. Racial scripts are programmed messaged from parents to children about African Americans of which the children, even when they have become adults, are not fully aware. They can have a powerful influence, so it's important for psychologists to recognize their own racial scripts and alter them to meet the reality of the African American community.

Psychologists should also be aware that clients may hold different world views that are diametrically opposed to their own, which could cause a problem in therapy. The psychologist must know his or her own strengths and limitations. African Americans are not a monolithic group: there is a great diversity within the culture, including some who hold very strong pro-black beliefs, and some who are anti-white. It's important for psychologists to know who they're comfortable with, and why a client might make them comfortable or uncomfortable. It's also important to know the reasons behind the comfort or lack of comfort. If a psychologist recognized a strong discomfort working with a particular kind of client, it might be preferable to

refer out, or seek supervision on the case, because working with such a client could do more damage than benefit.

5. Any other thoughts about culturally competent practice with African Americans?

There's no magic bullet, but the psychologist should strive to acquire a broad spectrum of knowledge about African American culture, including music, literature, language, or other aspects of culture. Gain experience with African Americans and revise one's own racial scripts by comparing those scripts with the real, one-on-one personal experiences they have with African American people.

If the psychologist's racial scripts are negative, they might seek out only those experiences that confirm the scripts, so they won't become modified. Instead, they should seek out different kinds of experiences, not just certain TV shows or other images that with confirm the negative. Seek out experiences that could invalidate the negative racial scripts in order to test whether the scripts are valid or invalid. Discussing these experiences with others can further help the psychologist increase cultural competence.

Resources:

Mitchell, H. (1971). Counseling black students: A model in response to the need for relevant counselor training programs. Counseling Psychologist, 2, 117-122.

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Monica McGoldrick, LCSW, Ph.D.
Irish-American clients

Biographical Sketch

Monica McGoldrick is the Director of the Multicultural Family Institute of New Jersey and Adjunct Associate Professor of Clinical Psychiatry at UMDNJ-Robert Wood Johnson Medical School. For 10 years she was Visiting Professor at Fordham University School of Social Service. She is a nationally known teacher, author, and family therapist whose many books include *Ethnicity and Family Therapy* (3rd ed., 2005).

1. In general, why is it important for clinical psychologists to be culturally competent when working with Irish American clients?

Many of today's Irish American clients are by now 4th or 5th generation in the US; their families came over in the 1840s or 1850s. So, they're a bit "watered-down," you might say, but the values and beliefs that are typical of the Irish are often still there- deeply rooted, and they are in many ways different from the dominant culture, so there can be misunderstandings with those coming from different backgrounds.

Traditionally (and I'm overgeneralizing a bit to make the point) the Irish, although they were big talkers, were not big talkers about emotional issues. In fact, they seemed afraid of emotional issues. So, if you asked them the kinds of questions that would, say, come from a Freudian perspective (which is still very strong in psychology), they would probably look much more pathological than they really are, because they would be extremely uncomfortable with questions about their inner feelings, especially negative feelings or sexual feelings. They might just have no words for their emotional experience. While they could tell you stories—and actually, stories are a much better ways to connect with the Irish, although they can use stories to distance themselves psychologically too—if you try to go after the emotional process by directly asking questions like "What are you feeling now?" they'll just feel very uncomfortable and possibly shut down. It's not that they're disturbed; the Irish have a long history in which they learned how to keep their emotional process under wraps, and often the church encouraged certain attitudes which led them to feel guilty about some feelings that wouldn't even be an issue in other cultural groups.

2. What can clinical psychologists (or students in training) do to *enhance* their cultural competence with Irish American clients?

In general—not just with Irish Americans, but with clients of all cultural backgrounds—we should work on our own cultural humility. Don't assume that you know what the other person means, and in general be more curious than judgmental. Actually, we often get paid to be judgmental—to put people into diagnostic categories, etc.—and that presses us to make judgments about how people respond emotionally. But for many groups including Irish Americans, we should never be too sure that we are right, so we should not make such judgments, especially if you come from a culture that is very different. And if you're Irish yourself, you should probably think about how those values play out for you, because you might accept that you and your client are uncomfortable talking about certain things, but avoiding those things might not be the most useful thing to do. For clients of all cultures, the best thing to do is look at your own cultural background and values. And the next thing after you look into yourself is to try to engage with the other person from a very humble, listening position, and try to learn from them about their cultural experience.

3. What specific considerations should clinical psychologists keep in mind when conducting *assessment* (interviewing, intelligence testing, personality testing, etc.) *and diagnosis* with Irish American clients?

One of the first things that comes to mind is the use of alcohol. It has traditionally been very much accepted in Irish culture, and the Irish have had a very long, sad history of alcohol abuse. Drinking is very socially accepted, and they assume it is normal, so they may not tell you about it. If you come from another culture that doesn't drink that much, you might overlook this issue. So, during an assessment you would do well to inquire about drinking patterns.

Also (and this may be changing in recent generations), Irish Americans often show a tendency to deny a lot of psychological issues as problems but in fact they are blaming themselves. For example, regarding sexual issues, they might obsess about sexual thoughts and blame themselves for it, but if you ask them, they might say nothing's happening. In a similar way to how the church covered up and denied sexual abuse, there's a covering up of emotions regarding sexuality and abuse. We must be careful to assess this self-blame and humiliation related to others knowing their thoughts and feelings. They tend to blame themselves and not tell others, because they think it's bad enough to have the problem in the first place, but if someone else finds out about it, now there are two problems.

Another issue that has been much discussed in the literature is high reported rates of schizophrenia among the Irish. This appears a bit surprising, because Irish families also tended to have a high tolerance for unusual thinking and behavior. They tolerated it without labeling it or seeing it as a problem, although this has changed a lot, I think, in recent times. Compared to cultural groups that value logic and truth, the Irish have not placed as much importance on logic or truth. Dreams are often seen as more important than truth, perhaps because historically the truth was very harsh and life was very harsh.

Additionally, there is a tendency—probably more true among older Irish Americans now than younger family members—to be fatalistic. They believe that this life is about struggling and suffering, and death is a release from this world's suffering, so death is celebrated. In this way, they would appear to accept feeling depressed, and might resign themselves to the idea that they

can't change their circumstances or their fate (for example, a diagnosis of a serious physical illness). This may stem from a long history of living in a situation in which they couldn't change their circumstances. This is true for some other oppressed groups as well.

4. What specific considerations should clinical psychologists keep in mind when conducting *psychotherapy* with Irish American clients?

Go slow, and don't expect them to be very effusive or to understand feelings very well. For some therapists—perhaps Jewish, Italian, or Puerto Rican therapists—Irish clients might seem boring. They will tell stories, but they may seem very shut down emotionally. But they're better than they appear, and they might appreciate the therapy much more than they will let you know. So even a little bit of making them feel more connected can be very important to them, especially because they have a tendency to cut off from others. If you help them make a little connection, you may not feel gratified that you've done much, but you may have actually made a big difference. I've had the experience myself many times as a therapist: I would think the therapy was a bit tense or boring or difficult, but to the client, it was quite valuable. I can remember one client who came back years after therapy ended and said, "the five sessions our family had with you changed our lives." I would have never known that from their reactions during therapy—they never said a thing at the time. So, they might actually be getting a lot more out of therapy than they let you know.

They won't appreciate you confronting them directly about why they don't express their feelings more. That's not going to be helpful. Trying to get them to be more dramatic or effusive—as Italians or Jews, who tend to enjoy engaging and getting their feelings out, are more likely to be—is not a good idea. The Irish, generally, do not think it's good to get your feelings out. If you are confrontational about this, they might feel humiliated and bad about themselves and you.

Using humor and positive connotation while keeping your eye out for the underlying process that they don't easily share is your best bet. Avoid negative connotations, such as a hypothesis about "deep down" Freudian issues such as unacceptable feelings toward mother or father. Irish Americans would find those very unappealing ways of thinking about their lives, and they would not lead to productive therapy. If you realize that they mean well and are trying to do the right thing, the therapy will be much more likely to succeed.

5. Any other thoughts about culturally competent practice with Irish American clients?

I think the main points are: be careful about their embarrassment about therapy, be careful not to humiliate them, don't accuse them of underlying negative thoughts, and don't pressure them to be very expressive about emotional issues. Acceptance and cultural humility and good listening on the part of the therapist will take you much further.

Nadya Fouad, Ph.D.
Female clients

Biographical Sketch

Nadya A. Fouad, Ph.D. is a Distinguished Professor in the Department of Educational Psychology at the University of Wisconsin-Milwaukee and training director of the Counseling Psychology program there. She is editor of *The Counseling Psychologist*. She was recipient in 2003 of the John Holland Award for Outstanding Achievement in Career and Personality Research, and the 2009 APA Distinguished Contributions to Education and Training Award and Janet Helms Award for Mentoring and Scholarship. She was President of Division 17 (Counseling Psychology) from 2000-2001. She is a past chair of the Council of Counseling Psychology Training Programs (2003-2007). She was a member and chair of the Board of Educational Affairs (2004-2006). She has been chair of the Competencies Workgroup (2006-present). She serves on the editorial boards of the, *Journal of Vocational Behavior* and the *Journal of Career Assessment.* She has published articles and chapters on cross-cultural vocational assessment, career development of women and racial/ethnic minorities, interest measurement, cross-cultural counseling and race and ethnicity. She is currently working on studies to examine the persistence of women in engineering careers. She served as co-chair (with Patricia Arredondo) of the writing team for the Multicultural Guidelines on Education, Training, Practice, Research and Organizational Change, which were approved by the American Psychological Association in August, 2002 and published in the *American Psychologist* in May, 2003.

1. In general, why is it important for clinical psychologists to be culturally competent when working with female clients?

We have an ethical imperative to be as effective as possible with our clients, and taking into account all kinds of cultural variables, including gender, makes us more effective. It's important to understand how a client's gender is interwoven his or her culture or ethnicity. For example, a traditional Hispanic woman facing a decision like moving across the country to go to college and moving away from her family might experience that decision in a unique way, and differently from a man in the same situation. If a client senses that the psychologist isn't taking these kinds of issues into account, the client might not return at all.

2. What can clinical psychologists (or students in training) do to enhance their cultural competence with female clients?

For graduate students, the training program should provide coursework in this area. There are things that undergrads can do too: taking anthropology courses, literature courses that provide exposure to different worldviews, seeking opportunities to attend community events to gain familiarity with different groups—anything that helps you learn about other cultures. There's a

wonderful movie called *Real Women Have Curves* about a young Latina woman in East Los Angeles who struggles with a decision about attending Columbia University in New York or remaining at home with her family and their business—it's an example of a movie that does a great job of illustrating the role that gender can play within a specific culture. In the field of cultural competence we emphasize awareness, knowledge, and skills. Undergrads can certainly enhance their self-awareness and knowledge, and in graduate school, the skills become more of the focus.

3. What specific considerations should clinical psychologists keep in mind when conducting assessment (interviewing, diagnosing, intelligence testing, personality testing) with female clients?

It's important, especially when interviewing, not to overpathologize. There's a long history of overdiagnosis of women with certain diagnoses, such as depression. During an assessment, the psychologist needs to account for gender socialization as well as the way that women have typically presented problems and their willingness to express emotion when they do. Actually, gender, in combination with culture, helps determine whether clients seek therapy and what they focus on when they are in therapy. In terms of testing, particularly testing that is vocational in nature or has anything to do with career decisions, it's important to help female clients consider options that are beyond stereotypically feminine career, encouraging women to consider, for example, careers in math and science. Of course, if they want to consider more traditional careers, those shouldn't be ruled out, but careers that have traditionally been more atypical for females should also be considered.

4. What specific considerations should clinical psychologists keep in mind when conducting psychotherapy with female clients?

Be aware of your own biases with regard to gender. For example, do you have a bias toward women being in a particular role, either traditional or nontraditional? Do you have a bias toward one type of relationship in which women should be? It's also important to be aware of how socialization can affect the way a female client makes or doesn't make changes. A classic example is the battered woman who stays with the abusive man. The psychologist needs to understand that the factors that facilitate change in her may be different than the factors for they would be for a man in a similar situation. Also, other cultural variables like ethnicity also play a big role here too. Gender intersects with culture very uniquely in different cultural groups.

5. Any other thoughts about culturally competent practice with female clients?

Remember that you can't take the client out of his or her cultural context, which is shaped by gender first and foremost. Gender is the most salient socializing factor, whether you accept or reject traditional gender-based socialization. We don't want to overemphasize the differences between men and women, but we don't want to overlook them and pretend men and women are the same either. Psychotherapy is not "one size fits all"—it needs to be customized for the person you're working with, and gender is one of the most important factors to keep in mind in this regard. Damage can be done if the psychologist fails to do this: women can be encouraged to stay in marriages that are bad for them, they can be overdiagnosed, overmedicated, labeled as "too emotional," or not encouraged to reach their potential. There was a classic study by Broverman and others (Broverman et al., 1970) in which the primary finding was that clinicians thought that the characteristics of a psychologically healthy, mature adult were more similar to the characteristics of a man than the characteristics of a woman. To me, that study is still relevant

today, and it emphasizes how important it is for psychologists to appreciate the impact of gender issues, especially when working with female clients.

Resources:

Broverman, I. K., Broverman, D. M., Clarkson, F. E., Rosenkrantz, P. S., & Vogel, S. R. (1970). Sex-role stereotypes and clinical judgments of mental health. *Journal of Consulting and Clinical Psychology, 34*, 1-7.

Karen Haboush, Psy.D.
Middle Eastern clients

Biographical Sketch

Karen Haboush is Visiting Associate Professor, Applied Visiting Faculty at the Graduate School of Applied and Professional Psychology at Rutgers University. She has published journal articles and book chapters on clinical supervision, psychological assessment, and culturally-competent psychological practice with children and families of Middle Eastern descent.

1. In general, why is it important for clinical psychologists to be culturally competent when working with Middle Eastern clients?

There are several reasons why it is important for psychologists to be culturally competent when working with clients of Middle Eastern descent. Increasingly, Middle Easterners are identifying as a distinct ethnic group within the United States, numbering approximately 3.5 million. They comprise a diverse group of individuals in terms of race and religious affiliation. However, owing to media coverage of events in the Middle East, considerable misinformation also exists regarding this group. Because the popular media often presents predominantly negative images of Middle Easterners (i.e., terrorists, religious extremists), psychologists may unwittingly internalize these images which subsequently influences their clinical work. As with all ethnic groups, the first step in developing cultural competence is for psychologists to examine their own attitudes and knowledge about a particular group.

A brief overview may help to clarify some facts about Middle Easterners. There is some overlapping use of the terms Middle Easterner and Arab but not all Arab countries are in the geographic region generally considered to constitute the Middle East. In general, the 22 Arab countries are considered to be those in which Arabic is the primary language, although other languages may also be spoken. Middle East countries include: Lebanon, Jordan, Kuwait, Syria, Iraq, Egypt, Morocco, Saudi Arabia, Yemen, and the United Arab Emirates. Despite variability, these countries share unifying cultural values in terms of the central importance of family and religion. In Middle Eastern culture, the welfare of the family has much greater significance than individual autonomy and independence and psychological well-being is often equated with interdependence upon one's family. This makes Middle Eastern culture quite different from the prevailing emphasis on individual achievement which is more characteristic of North American and European countries. Of course, great variability exists across cultures and countries, but generally speaking, a collectivist emphasis on the well-being of the family tends to characterize the Middle East. Thus, for psychologists, one of the first steps in working with clients of Middle Eastern descent is to assess the degree to which the individual feels more identified with Middle

East/Arab culture or North American/European culture. A client's identification will influence the course of clinical work.

Although most Middle East countries are predominantly Muslim, being Middle Eastern is not synonymous with being Muslim. Christians, Jews, Druze, and other religious denominations can be found in the Middle East. Assessment of religious observance is also recommended since this may have implications for therapeutic interventions.

More recent Middle Eastern immigrants to the United States are arriving with histories of trauma, owing to various wars. For Middle Easterners living in the United States, experiences of discrimination have been shown to increase following political events. Discrimination sometimes prompts clients to seek treatment. Following the Sept. 11th attacks, reports of discrimination against individuals of Middle Eastern descent, including school children, have increased.

2. What can clinical psychologists (or students in training) do to enhance their cultural competence with Middle Eastern clients?

One of the most important steps to enhancing cultural competence with Middle Eastern clients involves obtaining current, accurate information about Arab culture. Research suggests that the popular media (i.e., movies such as "Aladdin") tends to portray very negative images of Middle Easterners, thus perpetuating stereotypes (i.e., "Arabs are terrorists/religious fanatics"). Even classroom textbooks have been shown to portray Middle Easterners in a negative light. As such, obtaining accurate information from more scholarly sources and, if possible, interacting with individuals of Middle Eastern descent are strongly encouraged. Various websites provide current information on the United States Middle Eastern community (for example, the Arab American Institute Foundation site at http://www.aaiusa.org) and may also help to introduce psychologists to the worldview of Middle Eastern clients.

Direct exposure to Middle Eastern culture is recommended. Eating in Middle Eastern restaurants allows one to become familiar with the food as well as the tradition of hospitality, which is highly valued. (In fact, hospitality is so important that clients will sometimes bring gifts of food to psychologists; these should be accepted in the interest of maintaining rapport). Meals are also important times for observing family interaction and communication styles. Visiting Middle Eastern grocery stores may help familiarize psychologists with the dietary practices observed under Islam. Observant Muslims eat food that is considered *halal*. Pork, pork products, and alcohol are forbidden under Islam.

Attending cultural (i.e., music, dance) and religious events may also be beneficial. Middle Eastern community organizations often sponsor events (see, for example, the Arab American Family Support Center website at http://www.aafscny.org) as well as provide resources which psychologists might utilize with clients. Churches, mosques and temples also host events that are open to the general public. Since religious leaders are very respected, opportunities for psychologists to build relationships with priests and *imams* can greatly enhance the likelihood of clients viewing psychological services as more acceptable. Such events may also help to illuminate the different traditions among religious groups regarding norms for socializing. For devout Muslims, for example, socializing between the sexes and loud music may not be permissible.

3. What specific considerations should clinical psychologists keep in mind when conducting assessment (interviewing, diagnosing, intelligence testing, personality testing) with Middle Eastern clients?

Traditionally, mental health issues have been a source of shame and stigma in Arab culture. Middle Easterners identified with Arab culture may be hesitant to speak with psychologists because of concerns about preserving family honor. Further, due to a cultural emphasis on respect for authority, clients may adopt a polite demeanor toward psychologists rather than openly display any disagreement. Thus, in order to gain accurate diagnostic information, psychologists may need to devote additional time to establishing rapport and providing psychoeducation about interviewing and assessment. Trust and open disclosure may be further impeded by the perception of many Middle Eastern individuals that owing to political events, many North Americans are not overly sympathetic to the worldview of Middle Easterners. Establishing rapport with Middle Eastern clients may necessitate psychologists conveying interest in understanding their client's worldview.

Since interviewing relies heavily on language, psychologists should assess the client's dominant language. Arabic is a very expressive, emotional language; some research suggests that clients appear more distressed and symptomatic when speaking Arabic, rather than English. At the same time, outward expression of emotion is often discouraged as a potential source of shame for the family and this may complicate diagnostic assessment. Certain subjects such as sex, sexuality, domestic violence, and incest may be considered taboo because of shame and religious teachings and clients may be reluctant to provide information when interviewed about these topics. Suicide is not permissible under Islam and devout Muslims may deny suicidal risk factors when queried. Assessment of feelings of hopeless may be more effective. Psychologists may find their clients are likely to discuss physical symptoms when they are anxious or depressed, as this is more culturally acceptable.

When conducting psychological testing, psychologists should remember that punctuality is not emphasized to the same degree in Arab culture as it is in North America. Therefore, some client's performance may reflect a lack of familiarity with working under timed conditions, rather than deficient ability. Social-emotional assessment may also reflect cultural differences. While drawings are commonly used to build rapport with children, this may present a conflict for Muslim children because of religious prohibitions against creating images. Therefore, psychologists should ask children whether it is permissible for them to draw. Themes of dependence upon others, rather than self-reliance, may also emerge in more open-ended personality measures, such as storytelling techniques (i.e., TAT, Roberts-II). Although North American psychologists tend to view greater autonomy and self-reliance as markers of psychological well-being, in Middle Eastern culture, greater concern for and reliance on the family is viewed as reflective of psychological health.

4. What specific considerations should clinical psychologists keep in mind when conducting psychotherapy with Middle Eastern clients?

Middle Eastern children are raised to look to their family to find solutions rather than looking inwardly at their own reactions. In contrast, Western models of psychotherapy (i.e., psychodynamic, family therapy) generally encourage clients to develop greater autonomy and independence from their family. However, such approaches may increase conflict for clients whose families are more identified with Middle Eastern culture, thereby contributing to their prematurely ending therapy. Therefore, as noted above, the first task in working with Middle

Eastern clients is to assess degree of acculturation to either Middle Eastern/Arab or North American/European culture. Clients who are more identified with Arab culture will benefit from psychotherapy that acknowledges the importance of family while gradually assisting the client in examining their own feelings and reactions.

Conducting psychotherapy may also require that the psychologist demonstrate respect for traditional gender roles and parent-child relationships. These patterns may be at odds with the psychologists' personal beliefs about gender equality and childrearing practices. For instance, as the father is regarded to be the head of Middle Eastern families, directly challenging the father's authority may hinder the development of an effective therapeutic relationship. Psychologists also need to remember that observant Muslim clients view prolonged eye contact and touch between non-family members of the opposite sex as inappropriate. This includes, for example, hand shaking. Psychologists should, therefore, consider the impact of gender differences when conducting psychotherapy. Some parents may refuse to give permission for their children to be treated by a psychologist of the opposite sex and/or to participate in group counseling with children of both genders.

The combination of respect for authority figures and the tendency to look to others for solutions means that some Middle Eastern clients will benefit from psychoeducation about the importance of their assuming an active role in psychotherapy.

Kathleen J. Bieschke, Ph.D.
Lesbian/Gay/Bisexual/Transexual (LGBT) clients

Biographical Sketch

Dr. Kathleen J. Bieschke is a Professor of Counseling Psychology in the Department of Counselor Education, Counseling Psychology, and Rehabilitation Services at the Pennsylvania State University in University Park, Pennsylvania. Dr. Bieschke is an active participant in the field of counseling psychology. She served as the secretary for the Council of Counseling Psychology Training Programs from 2001-2004 and as the Vice-President for Education and Training of the Society of Counseling Psychology from 2004-2007. She has served on the editorial boards of the *Journal of Counseling Psychology* and *The Counseling Psychologist*, and is currently Associate Editor for *Training and Education in Professional Psychology*. A Fellow of two divisions of the American Psychological Association (i.e., Division 17, Society for Counseling Psychology and Division 44, Society of Gay, Lesbian, Bisexual, and Transgender Issues), Dr. Bieschke has published over 50 professional journal articles, chapters, and edited books. She has received numerous awards including the 2000 Fritz & Linn Kuder Early Career Scientist Practitioner Award given by Division 17 of the American Psychological Association, the 2001 Distinguished Book Award by Division 44, and the 2009 Distinguished Contribution to Education and Training given by Division 44. Dr. Bieschke has written about and conducted research pertaining to the delivery of affirmative counseling and psychotherapy to gay, lesbian, and bisexual clients. Most notably, Dr. Bieschke was a co-editor for two editions of the *Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients.*

1. In general, why is it important for clinical psychologists to be culturally competent when working with LGBT clients?

I firmly believe that all clinical psychologists have an obligation to prepare themselves to work competently with clients from all cultures, particularly those who represent oppressed and marginalized groups. In addition, it's likely that most clinical psychologists will encounter LGBT clients as this population tends to have a high rate of utilization of mental health services given the amount of minority stress they face. And, despite numerous resolutions and reports from APA asserting that a sexual minority status is not in and of itself pathological, most students in training will find that they, consistent with the dominant view in society, hold heterosexist views. Some clinical psychologists may find that their personal values are antithetical to the profession's stance. While I do not believe it is reasonable (or ethical) to insist that all clinical psychologists hold values similar to that of the profession, I do believe that all clinical psychologists are obliged to resolve such values conflicts in order to provide competent services to sexual minority clients. This is particularly important given the extent to which sexual minority clients are often vilified

in our society and it is likely that LGBT clients will attempt to determine the extent to which a treatment provider is affirmative of their sexual minority status.
Students in training must prepare themselves prior to even working with sexual minority clients as such clients may hide their identity from their therapists. This may be because as discussed earlier, clients are often uncertain about the depth of affirmation they will encounter when seeking treatment. In addition, depending on what age group the client represents, he/she may not know themselves whether they are a sexual minority. Similarly, there is some evidence to suggest that sexual orientation can be fluid, particularly for women, and thus it's possible to begin treatment working with someone who identifies as heterosexual but who, during the course of treatment, begins to explore a sexual minority status.

2. What can clinical psychologists (or students in training) do to enhance their cultural competence with LGBT clients?

Consistent with APA's Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists, what seems most important is that students attempt to enhance self-awareness while expanding their knowledge about sexual minorities. Further, attempting to understand both the dominant culture as well as the LGBT culture from the perspective of those who are sexual minorities is essential. A wide range of methods exist for doing so including the popular media (e.g., books, movies); media directed towards LGBT individuals (e.g., The Advocate); existing empirical evidence in peer-reviewed journals; or exercises that foster self-reflection on the development of one's own biases. A particularly fruitful strategy is getting to know someone who identifies as a sexual minority or as a strong ally; relationships such as these can shatter stereotypes and assumptions. As part of this process, it's essential for students to learn the positive aspects of identifying as a sexual minority rather than focus exclusively on how difficult it is to be LGBT.
Once students have critically examined their biases and expanded their knowledge base, seeking supervised skill-building experiences seems critical to developing competence. Even if one considers him- or herself to be affirmative, I believe it is essential to be vigilant about the manifestation of heterosexism. My belief is that all of us are heterosexist; it would be hard not be given that heterosexuality is the dominant sexual orientation in our society. Eradication of biases is likely impossible and what is essential is our awareness of our biases, the willingness to critically examine them, and the skill to minimize their influence on our ability to act in the best interests of our clients. These are topics that are often best explored in clinical supervision.

3. What specific considerations should clinical psychologists keep in mind when conducting assessment (interviewing, intelligence testing, personality testing, etc.) and diagnosis with LGBT clients?

As mentioned previously, there is no evidence to suggest that a minority sexual identity is, in and of itself, pathological. Yet, identifying as a sexual minority brings with it a certain amount of stress, as LGBT individuals must only contend with a society that is largely unaffirmative of sexual minorities. These individuals may also struggle with the internalization of the messages they receive by society. The extent to which people struggle with their sexual minority identity is influenced by many factors including the extent to which their immediate environment (e.g., home, church, geographic location, peers, school) is affirmative as well as individual characteristics such as personality, family dynamics, health considerations, and other salient identities such as race/ethnicity, religion, and disability status.
Assessment and diagnosis is further complicated by the client-therapist relationship. As noted previously, clients often approach treatment with a certain amount of trepidation and seek to

ascertain the extent to which the provider is affirmative. Such behavior may serve as a barrier to accurate assessment and diagnosis. And of course, accurate assessment and diagnosis can only occur if clinical psychologists are aware of their biases and minimize their influence on this important decision-making process.

It's also important to recognize the complex historical relationship LGBT individuals have had (and continue to have) with the mental health profession. In the early 1970's, a minority sexual orientation was listed as a diagnosable disorder and currently, there are different schools of thoughts about whether gender identity conflicts constitute a diagnosis. Being knowledgeable about and sensitive to these issues can only serve to foster the therapeutic relationship.

4. What specific considerations should clinical psychologists keep in mind when conducting psychotherapy with LGBT clients?

As is true for most effective psychotherapy, particular attention must be paid to the development of a productive therapeutic relationship. This is particular true when working with sexual minority clients, as LGBT individuals have learned to carefully assess the extent to which therapists are affirmative. There are a myriad of ways in which therapists can convey affirmation to clients. For example, having a symbol in one's office indicating knowledge of the LGBT community (e.g., a small pink triangle) or using language that is inclusive (e.g., not using gender-specific pronouns when referring to sexual partners) can provide LGBT clients with concrete evidence of a therapists openness to sexual minorities.
A particularly useful resource for clinical psychologists is the APA's *Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients.* In addition to addressing the importance of understanding how attitudes towards sexual minorities can influence treatment, the *Guidelines* also highlight the complex and unique ways in which families, other salient relationships, and issues of diversity might influence a client's experience of his/her sexual minority identity.
In 2009, APA adopted the "Resolution on Appropriate Affirmative Responses to Sexual Orientation Distress and Change Efforts." This resolution, based on the available empirical evidence, affirms same-sex behaviors, feelings, and attractions as a normal variation of human behavior. Further, this resolution notes that the existing empirical evidence does not support any therapeutic efforts focused on changing a client's sexual orientation and advises clients to avoid such treatments. Rather, clients are urged to seek services "that provide accurate information on sexual orientation and sexuality, increase family and school support and reduce rejection of sexual minority youth." This report also noted that because some clients are in distress because of the extent to which their sexual orientation conflicts with their religious beliefs, they may seek to change their sexual orientation. For these clients, it is recommended that providers treat such clients by helping them to "explore possible life paths that address the reality of their sexual orientation, reduce the stigma associated with homosexuality, respect the client's religious beliefs, and consider possibilities for a religiously and spiritually meaningful and rewarding life."

5. Any other thoughts about culturally competent practice with LGBT clients?

Clearly, LGBT is an umbrella term that is inclusive of both sexual and gender minority identities. As is so true of so many cultures, there are obviously as many differences (if not more) within the LGBT community as there are between sexual minorities and heterosexuals. Thus, to be truly competent it is essential for students-in-training to become aware of and knowledgeable about these within group differences.

In particular, it is critical for students-in-training to increase their understanding of both bisexual and transgender individuals. For example, the salience of bisexuality is often negated by the common assumption that a person's partner is ultimate determinant of one's sexual minority status. As a result, the unique experience of bisexual individuals is often overlooked or dismissed. Similarly, the lack of visibility as well as the lack of existing information about transgender individuals often leads to the perpetuation of negative stereotypes and biases about this population.

In addition, to be truly competent to work with LGBT individuals, one must become an historian, as a client's age has the potential to provide clinical psychologists with much needed context about their lives. Societal views of LGBT individuals are changing rapidly and greatly influence the challenges LGBT individuals face (e.g., the right to marry, adopt, to be protected against crimes). Advances in technology are also influencing the lives of LGBT individuals. For example, the internet has fostered community among transgender individuals and advances in reproductive medicine have opened up new possibilities for creating families.

Lastly, much of this interview has been focused on students in training who identify as heterosexual and I don't want to overlook those who identify as LGBT. My hope for all of you is that you successfully identify a training program that is affirmative of sexual minorities. This will enable you to direct your energy towards developing the skills and competencies you will need to thrive as a clinical psychologist. Many students join Division 44 (Society for the Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues) of the American Psychological Association as it provides excellent support and resources to students in training.

Lewis Z. Schlosser, Ph.D.
Jewish American clients

Biographical Sketch

Dr. Lewis Z. Schlosser is an Associate Professor of Counseling Psychology in the Department of Professional Psychology and Family Therapy at Seton Hall University. Dr. Schlosser received his B.A. in Psychology (1994), M.A. in Rehabilitation Counseling (1997), and his Ph.D. in Counseling Psychology (2003) from the University of Maryland. He completed his pre-doctoral internship at New York-Presbyterian Hospital/Weill Cornell Medical Center. Dr. Schlosser is a New York state licensed psychologist, and is Board Certified in Counseling Psychology by the American Board of Professional Psychology (ABPP). He is a Fellow in the American Academy of Counseling Psychology.

Dr. Schlosser has several research interests and uses both quantitative and qualitative methods. His primary research agenda has been focused on the investigation of the advisor-advisee relationship in graduate school. This reflects Dr. Schlosser's broader interest in professional training relationships in psychology and their effects on relevant outcomes for students and faculty. Dr. Schlosser is also interested in multicultural counseling and development, specifically the intersection of race, religion, and ethnicity. His program of research on Jewish issues is focused on anti-semitism and identity development. Relatedly, Dr. Schlosser is interested in understanding and dismantling Christian Privilege – the unearned benefits afforded to Christians in the United States.

In addition to serving as the Practicum Coordinator, Dr. Schlosser teaches several courses in the counseling psychology Ph.D. program at Seton Hall; these include Personality Assessment, Practicum II (Racial Issues in Counseling), Seminar in Psychopathology, and Special Topics in Research and Evaluation. Dr. Schlosser serves on the Editorial Boards of several journals, including the *Journal of Multicultural Counseling and Development* , *Counseling and Values Journal*, *Training and Education in Professional Psychology*, and the *Psychology of Religion and Spirituality*. He was the recipient of the 2008 Early Career Mentoring Award from Division 17's Section on Ethnic and Racial Diversity, the 2008 Researcher of the Year Award from Seton Hall University's College of Education and Human Services, and the 2007 Emerging Researcher Award from the New Jersey Psychological Association.

1. In general, why is it important for clinical psychologists to be culturally competent when working with American Jewish clients?

First and foremost, clinical psychologists are likely to encounter American Jewish clients in their practice. Empirical data (e.g., Yeung & Greenwald, 1992) and anecdotal evidence both support the conclusion that Jews are generally comfortable with seeking psychotherapy. Hence, clinical

psychologists need to be prepared to handle the issues associated with this particular group of people.

Second, being Jewish is often the central facet of a Jewish person's identity. As noted by Schlosser (2006), "Judaism is a culture, a religion, an ethnicity, and a set of traditions that is embedded in Jewish people's expectations, belief systems, and family dynamics (p. 424)." As such, Jews confound established notions of race, ethnicity, and religion. Basically, we are not neatly nor easily categorized in a single box on a census form. This is because of the incredible diversity of Jews; there are many ways to be Jewish across race, ethnicity, sexual orientation, country of origin, and religious denomination. Of course, there are also some Jews who are highly assimilated into the dominant culture and others who have intermarried - Jewish identity may be less central for these folks. And so, clinical psychologists need to understand the within-group variabiltiy of American Jews - no two Jews are exactly the same.

Third, the persistence of negative Jewish stereotypes and anti-semitism warrants that psychologists strive for cultural competence with this group. American Jews are only 60 years removed from the Shoah (the Holocaust), in which roughly one-third of the world's Jewish population was murdered. Furthermore, recent data suggest that anti-semitism has not abated - one in six Americans holds strongly antisemitic views (Anti-Defamation League, 2005) and Jews are overrepresented among victims of hate crimes (Federal Bureau of Investigation, 2005). Therefore, psychologists must consider anti-semitism-related stress as a potentially relevant clinical issue for treatment. When a person of Jewish lineage commits a crime, there is often an increase in anti-semitism - as if one person's aberrant actions condemns a whole group. We see this happen a lot for People of Color and LGBT people; however, when a White man commits a crime, he is not somehow responsible for the credibility of White men everywhere. For Jews, this process also occurs on a national level - anti-semitism tends to increase when tensions rise in the Middle East.

Fourth, American Jews must deal with the stress of navigating an overwhelmingly Christian society, despite the assertion that there is no state-sponsored religion. This contextual factor is something I've coined "Christian Privilege;" you can read more about in my 2003 paper entitled "*Christian Privilege: Breaking a Sacred Taboo*."

Finally, it is important to note that being Jewish is largely an invisible minority status. Psychologists might never know that they have a Jewish client in front of them unless the client discloses her or his identity. Because Jews have endured a long history of oppression, many American Jews will assess the safety of the current environment prior to disclosing their identity. A culturally competent psychologist will strive to foster an environment of safety so that the American Jewish client would feel comfortable disclosing her or his Jewish identity.

2. What can clinical psychologists (or students in training) do to *enhance* their cultural competence with American Jewish clients?

Multicultural competence has been articulated to be comprised of three components: awareness, knowledge, and skills with regard to professional interactions with people from culturally diverse groups. Enhancing cultural competence with American Jews would be no different - it is important to increase awareness (e.g., about one's feelings about Jews), knowledge (e.g., facts about Jews), and skills (e.g., supervised clinical experience with American Jewish clients). Like with most learning, I believe that psychologists and students in training need both didactic and experiential components to enhancing their cultural competence with American Jewish clients.

In the didactic realm, this would include reading widely about Jews, Judaism, and anti-semitism. I highly recommend my 2006 paper entitled, "*Affirmative Psychotherapy for American Jews*" as an excellent place to start; other important scholars of psychology to read would include Peter Langman and Myrna Friedlander. Two of my own doctoral students, Rachel Adisy Suson and Rachel Shapiro Safran, are engaged in a program of research on Jewish issues - look for their work in the near future. From popular culture, I would recommend exposure to various Jewish groups, including the American Jewish Committee (www.ajc.org), American Jewish Congress (www.ajcongress.org), United Jewish Communities (www.ujc.org), the Anti-Defamation League (www.adl.org), the American Jewish Historical Society (www.ajhs.org), and the American Jewish Archives (www.americanjewisharchives.org). It would be equally important to read about the various denominations of Judaism, including the Union for Reform Judaism (www.urj.org), the United Synagouge of Conservative Judaism (www.uscj.org), and Union of Orthodox Jewish Congregations of America (www.ou.org), just to name a few. It is important to note here that this is just a sampling of the information that is available regarding Jews. The culturally competent clinical psychologist will consistently seek out greater knowledge about and experience with American Jews to provide the best possible care to these clients.

In the experiential realm, I'll start by recommending Gordon Allport's approach to preventing prejudice - contact. Psychologists and students in training must have actual contact with American Jews as peers (i.e., social equals) and as clients. Clinical supervision is essential for the psychotherapist unfamiliar and/or unexperienced with the treatment of American Jews. Further, psychologists and students should engage in a process of self-exploration with regard to American Jews. Here I would encourage people to examine their assumptions and beliefs about American Jews, regardless of the origins of said assumptions and beliefs. To enhance cultural competence, it is critical to engage in self-reflection on a regular basis to limit the impact of bias on the therapist-client relationship. Another strategy would be to engage in a cultural immersion experience, where the non-Jewish psychologist or student attends events where the audience is overwhelmingly Jewish. One such example for students would be going to the Jewish student union or attending a religious service at a temple or synagogue.

It is important to note that cultural competence is not assured simply by being Jewish. That is, we can't assume that Jews are going to be culturally competent with Jewish clients, as internalized anti-Semitism or other factors might be operating. Thus, Jewish psychologists (of which there are many) need to undergo similar processes with regard to improving their awareness, knowledge, and skills about Jewish clients.

3. What specific considerations should clinical psychologists keep in mind when conducting *assessment* (interviewing, intelligence testing, personality testing, etc.) *and diagnosis* with American Jewish clients?

Before beginning, please remember that considerations for assessment (and psychotherapy to follow) will vary depending upon the identity of the clinician - that is, whether the psychologist is Jewish or not. I'll operate from the assumption of the non-Jewish psychologist, and refer the interested reader to my 2006 paper (mentioned above) for a more detailed discussion of the assessment and psychotherapy considerations when the clinician is also an American Jew.

In an assessment of a Jewish client, it would be sound clinical practice to ask the client permission to explore the client's Jewish identity - as long as the clinician has a cogent rationale for exploring this material and a hypothesis about how this material might relate to the client's

presenting problems/referral question. I think it is important to understand the American Jewish experience and the aspects of Jewish life. This would include observing the Sabbath and keeping Kosher, among other things. The bottom line here is that an assessment should be made with regard to the client's sense of themselves as Jews, which would include both religious and secular/cultural components.

I think it is also important to be able to discern clinical paranoia from cultural mistrust, or what Terrell and Terrell (1981) call "healthy paranoia." Because of the extensive and pervasive history of anti-semitism, American Jews might be less than forthcoming without it being evidence of a paranoid process. When coupled with the fact that the mental health profession has historically viewed Jews negatively, then it becomes clearer as to why it is critical to develop rapport with American Jewish clients and to do so in a way that communicates respect and appreciation for American Jewish culture. Another challenging aspect of assessment and diagnosis with American Jews can occur when a highly religious Jewish client presents with obsessive-compulsive symptoms. The skilled and culturally competent clinician will work hard to determine when "religious" behavior becomes evidence of psychopathology and not just strict adherence to religious tenets.

When considering trauma during assessment and diagnosis, the clinician will need to conduct a thorough family history to determine if there are any Shoah survivors in the client's family. This is because there could have been an intergenerational transmission of trauma - the children and grandchildren of Shoah surviviors bring a unique dynamic with them to assessment and treatment (Rowland-Klein & Dunlop, 1997). This contextual data will assist the clinician in making an assessment and potential diagnosis with this subset of American Jewish clients.

Finally, psychologists should be knowledgeable about *shidduch* anxiety, which is anxiety symptoms associated with findings a good marital match in the Orthodox Jewish community. This is a real, valid concern, as getting married and having children are key life tasks for Orthodox Jews; indeed, having children is a great *mitzvot*.

4. What specific considerations should clinical psychologists keep in mind when conducting *psychotherapy* with American Jewish clients?

As noted previously, self-awareness is a key aspect of providing culturally competent psychotherapy with American Jews. Without such awareness, unconscious biases are likely to negatively impact the therapeutic process. It is also important to remember the centrality of Jewish identity - where being Jewish is often a critical component of a person's daily lived experience. In addition to this centrality, American Jews will often feel bicultural; that is, that they have two lenses (one Jewish, one American) with which to view the world (Friedman, Friedlander, & Blustein, 2005). Understanding this perspective should facilitate the psychotherapist's ability to empathically relate to their American Jewish clients. Langman (1997) noted that insight, introspection, and emotional expression are all generally valued by Jews and Jewish culture - this knowledge can help psychologists provide effective psychotherapy for these clients. At the same time, we can't assume that a person will be insightful and introspective simply because they are Jewish. It is important for the clinician to determine the importance Judaism plays in the client's life, and to make this determination at (or near) the outset of therapy. This will help guide the inclusion or exclusion of Jewish issues on the client's treatment.

Some other issues are worth mentioning as well. I think psychologists should not assume that a Jewish client can only be helped by a Jewish psychologist. As with assessment and diagnosis, it is

important to consider the possibility that internalized anti-semitism is playing a role with an American Jewish client. This could manifest in a variety of ways with regard to affect, behavior, and cognitions; however, the end result is often likely to be poorer psychological health for the American Jew experiencing internalized anti-semitism.

5. Any other thoughts about culturally competent practice with American Jewish clients?

Perhaps it goes without saying, but clinicians should not engage in stereotyping Jews. Reliance on stereotypes will lead to some faulty assumptions and likely damage the client-therapist relationship. I think culturally competent practice means attending to contextual factors, and this is critical to do when working with American Jewish clients. The State of Israel is a perpetual source of anti-semitic material, as there are a lot of strong emotions concerning Israel and her neighbors that can impact the daily lived experience of American Jews. In general, anti-semitism is a major problem facing American Jews, and it would be culturally incompetent to assert that anti-semitism is no longer a problem. Additionally, as mentioned above, the pervasive yet unspoken sense of what is normal in this country is Christian (much like it is White, male, heterosexual, and able-bodied), and Jews have to deal with the experience of being the other; this manifestation of Christian Privilege can be stressful for American Jews. Relatedly, it is also important to remember that Jews and Christians are quite different. The core value of Chrsitianity is forgiveness, whereas justice is the core value for Judaism. Jews are called to engage in *Tikkun Olam* (literally, "to heal the world"), perform good deeds (*Mitzvot*), and be involved with charitable organizations *(Tzedakah).* Understanding these facets of Judaism will help with culturally competent clinician understand the behaviors of American Jewish clients; this should translate into positive outcomes with those clients. Finally, it bears mentioning is that Jews are the most likely target of proselytizers (e.g., Jews for Jesus). As a American Jew living in New York City (the city with the largest Jewish population in the United States), one would think that I would be protected from daily anti-semitic microaggressions, but that is sadly not the case. So, whenever I encounter the Jews for Jesus folks who unfortunately inhabit my subway system on a semi-regular basis, I enjoy telling them that we already have a group of Jews for Jesus in the United States - they are called Christians!

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